SAINT MARY'S COLLEGE
NOTRE DAME • INDIANA

Pediatric Intake Form

Client Background Information	**Date:**			
Child's Name:	**Birthday:**	**Gender:**	**M**	**F**
Address:		**Age:**		
City:	**State:**	**Zip Code:**		
Emergency Contact				
Name:	**Relationship:**	**Phone#:**		

Primary Physician	
Name:	**Clinic:**
Phone#:	**Address:**
Referring Physician/Person	
Name:	**Relationship:**
Phone#:	**Address:**
REASON FOR REFERRAL:	

Responsible Party of Client (Parent/Caregiver/Guardian) Please Circle OR Fill in Answers							
Name:				**Birthday:**			
Address:			**City:**		**State:**	**Zip Code:**	
Phone:	**Home:**	**Cell:**		**Work:**			
E-Mail:							
Employment Status:	**Full Time**	**Part Time**	**Self Employed**	**Stay at home Parent**	**Retired**	**Disability**	**Unemployed**
Occupation:				**Employer:**			
Address:			**City:**		**State:**	**Zip Code:**	

Family Information (Please Circle OR Fill in Answers)								
Father (F):				**Mother (M):**				
Cell phone #:				**Cell phone #:**				
Birthday:				**Birthday:**				
Guardian/Caregiver other than Parent:								
Child Lives With:	**Mother and Father**	**Father**	**Mother**	**Grand-parents**	**Mother & Stepfather**	**Father & Stepmother**	**Relative**	**Foster Parents**
Primary Language:	**English**	**Spanish**	**Other:**	**Secondary Language:**	**Spanish**	**English**	**Other:**	
Sibling:								
Ages:								

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Birth and Medical History (Please Circle OR Fill in Answers)

Complications:	False Labor	Infection	High Fever	Gestational Diabetes	Bed Rest	Surgery	Accident	High Blood Pressure	Toxemia
Other:									

Use of Medications	NO	Yes Please List:
Exposure to Drug/Alcohol/ Smoke	NO	Yes Please state how long:
Complicated Delivery:	NO	Yes Please explain:

Premature:	NO	Yes	37 wks	36 wks	35 wks	34 wks	33 wks	32 wks	31 wks	30 wks	29 wks	28 wks	≤27wks

Type of Delivery:	Vaginal	C-Section	Breech	Twin	Triplet	Quadruplet

Birth Weight:		Birth Length:		Apgar:	

Medical Diagnoses at Birth:

Medical Conditions at birth:	Seizures	Brachial Plexus	Anoxia	Club Foot	Visual Deficit	Cleft Lip/ Palate	Hearing Loss	Reflux
	Failure to Thrive		Chronic Lung Disease		Heart Defect	Other:		

NICU Stay:	NO	Yes How Long:

Treatment Received In NICU:	Resuscitation	Jaundice Lights	Intubation	Ventilation	Oxygen
	MRI	ECHO	Eye Surgery	X-Rays	Isolation

Discharge Equipment Needed:	Oxygen	NG Tube	G-Tube	Apnea Machine	Tracheostomy
	Splints	Home Vent	Other:		

Current Medical History (Please Circle OR Fill in Answers)

Immunizations Current:	NO	Yes
Chronic Ear Infections:	NO	Yes How Frequent:
Tubes:	NO	Yes Date of Surgery:
Hearing Deficit:	NO	Yes Date of Last Exam: Please Explain:
Visual Deficit:	NO	Yes Date of Last Exam: Please Explain:
Respiratory Issues:	NO	Yes Please Explain:

Other Procedures:	X-ray Date:	CT Scan Date:	MRI Date:	Sleep Study Date:
Equipment Used:	Glasses	Hearing Aides	Cochlear Implant	Splints
	Eye Patch	Wheelchair	Walker	Bath Chair
		Stander	Braces (AFO – SMO)	Toilet Seat

Current Medications:

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ALLERGIES (please list):

Consulting Physicians Currently Treating Client:			
Name	**Specialty**	**Location**	**Phone#**

Developmental Milestones: (Please Circle OR Fill in Answers)				
When did your child:				
Sit Up:	6-8 Months	9-11 Months	12-14 Months	>15 Months
Roll from Tummy to Back:	2-4 Months	5-7 Months	8-10 Months	>11 Months
Crawl:	5-7 Months	8-10 Months	11-13 Months	>14 Months
Pull To Stand:	6-8 Months	9-11 Months	12-14 Months	>15 Months
Walk:	11-14 Months	15-17 Months	18-20 Months	>21 Months
Drink from a Cup:	4-6 Months	7-9 Months	10-12 Months	>13 Months
Start Using a Spoon:	7-9 Months	10-12 Months	13-15 Months	>16 Months
Spoke First Word:	10-12 Months	13-15 Months	16-18 Months	>19 Months

Does Child use Pacifier:	**NO**	**YES** Please Explain:
Drink from a Bottle:	**NO**	**YES** How many a day? How many ounces? What type of Nipple?
Potty Trained:	**NO**	**YES** At what age? Daytime and Nighttime?

Therapy and School History: (Please Circle OR Fill in Answers)						
Was/Is your child enrolled in any Early Intervention, Birth to Three Programs: (First Steps, Early On)						
NO	**YES** Please Explain:					
If Yes, did/do they receive:	**OT**	**PT**	**ST**	**Psychology**	**Dietician**	**Developmental Therapist**

If Yes, how often did/does each therapist visit:	**Weekly**	**Twice a Month**	**Monthly**	
Where does your child go to school:	**School:**	**Address**		
	City:	**Zip**	**phone:**	
How Often do they attend:	**1 day a week**	**2 days a week**	**3 days a week**	**4 days a week**	**5 days a week**

Do they receive therapy at school:

NO	**YES**	**If yes, do they receive:**	**OT**	**PT**	**ST**	**How Frequently:**	**1-2 days a week**	**2 days a month**	**Monthly**	**Consultation**

Additional Information:

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What are your child's IEP Goals related to speech therapy:
1.
2.
3.

Daycare and Additional Therapy: (Please Circle OR Fill in Answers)				
Does your child attend daycare:	NO	YES - If yes, Where and how often:		
Is your child currently receiving outpatient therapy:	NO	YES - If yes, Where and how often:		

Communication and Language: (Please Circle OR Fill in Answers)												
Percentage of Child's Speech Understood by:	Parent				Other Family Member				Stranger			
	<25%	50%	75%	100%	<25%	50%	75%	100%	<25%	50%	75%	100%
How do you know what your child wants:												
Can your child follow Verbal Commands:	NO	YES - Please Explain What They Can do When You Ask Them:										

Feeding: (Please Circle OR Fill in Answers)						
Does your child have food allergies:	NO	YES Please List:				
Does your child spit up during or after meals:	NO	YES – please explain:				
Does your child have reflux:	NO	YES – please explain:				
Does your child cough/gag/choke while eating:	NO	YES – please explain:				
Are there foods your child can't chew:	NO	YES – please explain:				
Does your child excessively drool:	NO	YES – please explain:				
Is your child a picky eater:	NO	YES – what foods do they like?				
		What food do they refuse?				
Does your child use a G-Tube:	NO	YES - Please List (Formula, Feeding Schedule, Use of Equipment, etc.):				
Does your child have constipation:	NO	YES - Please Explain:				
Frequency of Bowel Movements:	2 x day		1 x day	Every 2-3 Days	Every 5-7 Days	Weekly

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Fine Motor Skills: (Please Circle OR Fill in Answers)		
Are buttons/snaps/zippers difficult for your child:	NO	YES - What can they do on their own:
Does your child get dressed on their own:	NO	YES - What can they take on OR off (shirt, underwear, pants, shorts, socks, shoes):
		What can they put on (shirt, underwear, pants, shorts, socks, shoes):
Does your child have trouble with handwriting:	NO	YES - Please explain:
Does your child have trouble using Scissors:	NO	YES - Please describe how do they use scissors:
Does your child have trouble with utensils:	NO	YES - Please describe how they use a spoon/fork:

Sensory Motor Function: (Please Circle OR Fill in Answers)		
Does your child dislike hair wash/cut/brush:	NO	YES - Please describe:
Is your child fearful of movement:	NO	YES - Please describe:
Does Attention interfere with their daily routine:	NO	YES - Please explain:
Are they distracted by background noise:	NO	YES - Please explain:
Do they dislike getting messy:	NO	YES - Please describe:

Sensory Motor Function (continued): (Please Circle OR Fill in Answers)		
Do they get tired easily:	NO	YES - Please explain:
Is your child sensitive to lights/sounds:	NO	YES - Please describe:
Do large groups/crowds bother your child:	NO	YES - Please explain:

Have you used the following adaptations/therapeutic modalities:	NO	YES

Weighted Vest	Hug Vest	Disc-O-Sit	Brushing	Joint Compressions	Therapeutic Listening	Vision Therapy

If yes, please explain:

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Positioning/Sleep: (Please Circle OR Fill in Answers)							
What position does your child sleep:	Back	Side	Stomach	Other Describe:			
Do they sleep in a car-seat:	NO	YES Describe:					
Do they dislike being on their stomach:	NO	YES Please Explain:					
How long do they sleep at night:	2-4 Hours	4-6 Hours	6-8 Hours	8-10 Hours	10-12 Hours	>12 Hours	
Do they take a morning nap:	NO	YES - How Long:					
Do they take an afternoon nap:	NO	YES - How long:					

List Favorite Activities/Toys:
1.
2.
3.
4.

How do they express frustration/anger?

What type of praise works the best?

What is your biggest concern at this time?

What would you like to see your child be able to do better?

Please List any additional information that may be helpful below or on the back of this page. You may attach a separate page if desire.

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